



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Universal DME LLC

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-16-0823-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

November 24, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We have enclosed all supporting documents along with authorization from Travelers."

**Amount in Dispute:** \$85.36

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier has reviewed the reimbursement and determined the Provider was properly reimbursed for one month of rental."

**Response Submitted by:** The Travelers

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2015	E0730 -RR	\$85.36	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
  - P12 – Workers' compensation jurisdictional fee schedule adjustment
  - 309 – Charge exceeds fee schedule allowance

## Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. 28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;"

The applicable Medicare payment policy is found at, [www.cms.hhs.gov](http://www.cms.hhs.gov), Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), "In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months."

28 Texas Administrative Code 134.203(d) states,

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

The service in dispute will be calculated as follows:

- DMEPOS fee schedule 2015, Texas, E0730 (397.09) ÷ 10 (see above referenced Medicare payment policy) = \$39.70 x 125% = \$49.64.

2. The total allowable for the services in dispute is \$49.64. The carrier previously paid \$49.64. No additional payment is due.

## Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
December , 2015  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**